City of Gallatin
BlueCross BlueShield of Tennessee Voluntary Dental Plans
Effective 10-1-2014

Summary of Benefits	Dental Option 1	Dental Option 2	Dental Option 3
Deductible Calendar Year Applies to Coverage B and C Only	**Individual** $50 **Family** $150	**Individual** $50 **Family** $150	**Individual** $50 **Family** $150
Benefit Maximums Applies to Coverage A,B, and C Coverage D	$1,000 per Calendar Year	$1,000 per Calendar Year	$1,000 per Calendar Year $1,000 per Lifetime
Benefits Percentages Apply to	Any Dentist*	Any Dentist*	Any Dentist*
Covered Services	**Benefit Percentages**	**Benefit Percentages**	**Benefit Percentages**
Coverage A (Preventive) Exams, X-Rays, Cleanings, Fluoride, Sealants, Space Maintainers	100%	100%	100%
Coverage B (Basic) Basic Restorative Services Basic and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	50%	50%	80%
Coverage C (Major) Major Restorative and Prosthodontics	30%	50%	50%
Coverage C Waiting Period	12 Month Waiting Period Applies	12 Month Waiting Period Applies	12 Month Waiting Period Applies
Coverage D (Orthodontics) Orthodontics - Child to Age 19	Not Applicable	Not Applicable	50%
Coverage D Waiting Period	Not Applicable	Not Applicable	12 Month Waiting Period Applies
Network Option	Network Dentists paid at PPO fee schedule; Non-Network dentists paid at 70th percent of PPO fee schedule.	Network Dentists paid at PPO fee schedule; Non-Network dentists paid at 70th percent of PPO fee schedule.	Network Dentists paid at PPO fee schedule; Non-Network dentists paid at 70th percentile of Usual, Customary & Reasonable
DenteMax National Network	Included **	Included **	Included **
BluePerks	Discounts on routine vision care, Lasik surgery, weight loss and fitness centers, complementary / alternative medicine and more.		

Voluntary Employee Dental Rates	Dental Option 1		Dental Option 2		Dental Option 3	
	Monthly	Biweekly	Monthly	Biweekly	Monthly	Biweekly
EE Only	$16.43	$8.22	$28.13	$14.07	$32.36	$16.18
EE + 1 Dep.	$32.87	$16.44	$45.43	$22.72	$65.84	$32.92
Family	$56.67	$28.34	$69.74	$34.87	$121.70	$60.85

This document serves as a summary of benefits that are detailed in the Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions From Coverage, and Schedule of Benefits sections of the Evidence of Coverage.

When applicable, benefits will be paid based on the Benefit Percentages listed above. Members will be responsible for co-insurance (when benefit percentages are less than 100%), deductible(s), and all other charges when benefit maximums have been met.

*Members may see any dentist. BCBST has contracted dentists in our network that have agreed to limit their charges to our fee schedule. Because BCBST has no contract with non-network dentists, members may be responsible for any billed charges that exceed our Maximum Allowable Charge.

****BCBST also has a nationwide network**

>If a member changes to Option 3 from Option 1 or Option 2 at open enrollment, there will be a 12 month waiting period for orthodontics.

>Dependent children can stay on the dental plan until age 26. However, the orthodontics coverage is only to age 19.

Members are encouraged to use In-Network dentists for all services.

This summary was created by Premier Benefits Group/Coley Lyles Insurance. Please refer to your Evidence of Coverage for more details.